SUMMARY OF COSTS

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT COST	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (5)
1.	Dietary - Supplies and Expenses	B-7				
2.	Dietary - Raw Food	B-8				
3.	Medical Supplies	B-10				
4.	Habilitation Supplies	B-11				
5.	Prior Authorized Medical Equipment	B-13				
6.	Incontinence and Other Supplies	B-18				
7.	Nursing Aide Training	B-28				
8.	Nursing and Habilitation/Rehabilitation	B-60				
9.	Payroll Taxes	B-63				
10.	Utilities	B-67				
11.	Property Taxes	B-71				
12.	TOTAL Reimbursable Direct Costs (sum of lines 1 thru 11, use allowable patient days Sch. A line 4)	B-72				
	ADMINISTRATIVE AND GENERAL COST					
13.	TOTAL Administrative and General Costs (use allowable patient days Schedule A line 6.1)	C-30				
	OWNERSHIP COST					
14.	(use allowable patient days Sch. A line 6.2)	D-10				
	RENOVATION COST (use allowable patient days Schedule A line 6.2)					
15.	Renovation Amount & Interest Expenses 1981	D-11				
16.	Renovation Amount & Interest Expenses 1982	D-12				
17.	Renovation Amount & Interest Expenses 1983	D-13				
18.	Renovation Amount & Interest Expenses 1984	D-14				
19.	Renovation Amount & Interest Expenses 1985	D-15				
20.	Renovation Amount & Interest Expenses 1986	D-16				
21.	Renovation Amount & Interest Expenses 1987	D-17				
22.	Renovation Amount & Interest Expenses 1988	D-18				
23.	Renovation Amount & Interest Expenses 1989	D-19				
24.	Renovation Amount & Interest Expenses 1990	D-20				
25.	Renovation Amount & Interest Expenses 1991	D-21				
26.	Renovation Amount & Interest Expenses 1992	D-22				
	EQUITY					
27.	Return on Equity (Schedule E-1 line 24, col 5)	E-1				
28.	TOTAL (sum of lines 12 through 27)					

RECONCILIATION OF COSTS

	Schedule	Total (1)	Adjustments: Increases(Decreases) (2)	Adjusted Total (3)	*(Optional)*: Allocated Adjusted Total (4)
29.	B				
30.	C				
31.	D				
32.	Totals	$ (A)	$ (B)	$	$
33.	Less Non-Reimbursable from Schedule B and C				
34.	Total Reimbursable			(C)	(C)

(A) Agrees to total expenses per working trial Balance.
(B) Agrees to Attachment 2, line 24, Column 3.
(C) Agrees to Schedule A - 3, line 28, column 3.

TNS #92-24 APPROVAL DATE 3-19-93
SUPERSEDES
TNS #92-06 EFFECTIVE DATE 12-1-92

DIRECT COST

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT COST CENTERS	Chart of Account	Salary (1)	Other (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Alloc. (7)	Allocated Adjusted Total (8)
	DIETARY COSTS									
1.	Dietary Personnel (see footnote)	6010						4		
2.	Licensed Dietitian	6011						4		
3.	Other Contracted Dietary Personnel	6012						4		
4.	Staff Development	6013						4		
5.	Dietary Supplies and Expenses	6020						4		
6.	Employee Fringe Benefits	6030						4		
7.	Total Dietary Supplies and Expenses									
8.	Raw Food	6050						4		
9.	TOTAL Dietary Costs (sum of lines 7 and 8)									
	MEDICAL AND PROGRAM SUPPLIES									
10.	Medical Supplies	6070						5		
11.	Habilitation Supplies	6080						5		
12.	TOTAL (sum of lines 10 and 11)									
	MEDICAL EQUIPMENT									
13.	Prior Authorized Medical Equipment	6085						5		
	INCONTINENCE AND OTHER SUPPLIES									
14.	Incontinence Supplies	6089						5		
15.	Personal Care Supplies	6090						5		
16.	Other Program and Activity Supplies	6100						5		
17.	Records and Equipment	6110						5		
18.	TOTAL (sum of lines 14 through 17)									
	NURSE AIDE TRAINING									
19.	In-House Trainer Wages	6400						5		
20.	Classroom Wages: Nurse Aides	6410						5		
21.	Clinical Wages: Nurse Aides	6420						5		
22.	Books and Supplies	6430						5		
23.	Transportation	6440						5		
24.	Tuition Payments	6450						5		
25.	Contractual Payments to Other Nursing facilities	6460						5		
26.	Registration Fees and Application Fees	6470						5		
27.	Fringe Benefits	6480						5		
28.	TOTAL (sum of lines 19 through 27)									

FOOTNOTE	Hours Paid
Dietary Personnel	

DO NOT INCLUDE CONTRACTED PERSONNEL.

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TNS # 92-06 EFFECTIVE DATE ~~7-1-92~~

DIRECT COST

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT COST CENTERS	Chart of Account	Salary (1)	Other (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Alloc. (7)	Allocated Adjusted Total (8)
	ADMINISTRATIVE NURSING AND HABILITATION/REHABILITATION									
29.	Medical Director	6210						5		
30.	Director Nursing	6220						5		
31.	Supervising Nurse	6230						5		
32.	Medical Records Personnel	6240						5		
33.	Activities Director	6250						5		
34.	Pharmaceutical Consultant	6260						5		
35.	Other Medical & Social Service Personnel	6270						5		
36.	Contracted Therapy - Supervisory	6280						5		
37.	Purchased Nursing Services	6290						5		
38.	Utilization Review Personnel	6300						5		
39.	Staff Development	6310						5		
40.	Employee Fringe Benefits	6330						5		
41.	Other, Specify:									
42.	TOTAL Administrative - Nursing & Habilitation/ Rehabilitation (sum of lines 29 through 41)									
	DIRECT SERVICES									
43.	RN	6510						5		
44.	LPN	6520						5		
45.	Aides & Orderlies	6530						5		
46.	Recreational Therapist	6540						5		
47.	Psychiatric Social Worker	6600						5		
48.	Psychologist	6610						5		
49.	Respiratory Therapist	6620						5		
50.	Occupational Therapist	6630						5		
51.	Speech Therapist	6640						5		
52.	Audiologist	6650						5		
53.	Physical Therapist	6660						5		
54.	Therapist Aide/Specialized Services	6665						5		
55.	Specialized Services/Other	6670						5		
56.	Social Services/Pastoral Care	6680						5		
57.	Qualified Mental Retardation Professional	6690						5		
58.	Other Specify:									
59.	TOTAL Direct Services (sum of lines 43 through 58)									
60.	TOTAL Direct Services - Nursing & Habilitation/ Rehabilitation (sum of lines 42 and 59)									

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DIRECT COST

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT COST CENTERS	Chart of Account	Salary (1)	Other (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Alloc. (7)	Allocated Adjusted Total (8)
	PAYROLL TAXES - DIETARY AND NURSING									
61.	Payroll Taxes - Dietary Personnel	6750						4		
62.	Payroll Taxes - Nursing & Hab./Rehab. Personnel	6760						5		
63.	TOTAL Payroll Taxes (sum of lines 61 and 62)									
	UTILITY COSTS									
64.	Heat, Light, Power	6810						2		
65.	Water & Sewage	6820						2		
66.	Trash & Refuse Removal	6830						2		
67.	TOTAL Utilities (sum of lines 64 through 66)									
	TAXES									
68.	Real Estate Taxes	6860						2		
69.	Personal Property Taxes	6870						2		
70.	Franchise Tax (attach FT 1120)	6880						2		
71.	TOTAL Property Taxes (sum of lines 68 through 70)									
72.	**TOTAL Reimbursable Direct Cost** (sum of lines 9, 12, 13, 18, 28, 60, 63, 67, 71)									
	NON-REIMBURSABLE COSTS									
73.	Legend Drugs	6910								
74.	Radiology	6920								
75.	Laboratory	6930								
76.	Oxygen	6940								
77.	Other Specify:	6950								
78.	TOTAL Non-Reimbursable (sum of lines 73 through 77)									
79.	TOTAL Direct Costs (sum of lines 72 and 78)									

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ADMINISTRATIVE AND GENERAL

Name of Facility	Medicaid Provider Number	Reporting Period From:	Through:

	ADMINISTRATIVE AND GENERAL COST CENTERS	Chart of Account	Salary (1)	Other (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Alloc. (7)	Allocated Adjusted Total (8)
	REIMBURSABLE EXPENSES									
1.	Administrator	7010						7		
2.	Other Administrative Personnel	7020						7		
3.	Consulting and Management Fees	7030						7		
4.	Office and Administrative Supplies	7040						7		
5.	Copier	7050						7		
6.	Telephone and Telegraph	7060						7		
7.	Home Office Costs	7070						7		
8.	Travel - Motor Vehicle	7080						7		
9.	Travel and Entertainment	7090						7		
10.	Plant Operations and Maintenance	7100						2		
11.	Maintenance and Repairs	7110						2		
12.	Housekeeping	7120						2		
13.	Laundry and Linen	7130						7		
14.	Legal Fees	7200						7		
15.	Accounting	7210						7		
16.	Dues - Subscriptions and License	7220						7		
7.	Interest - Other	7230						7		
8.	Insurance	7240						7		
19.	Data Services	7250						7		
20.	Advertising	7260						7		
21.	Amortization of Start-up Costs	7270						7		
22.	Amortization of Organizational Costs	7280						7		
23.	Security Services	7290						7		
24.	Payroll Taxes - Schedule C Personnel	7320						7		
25.	Employee Fringe Benefits	7330						7		
26.	Staff Development	7340						7		
27.	Other Specify:							7		
28.								7		
29.								7		
30.	**TOTAL** Reimbursable Administrative and General Costs (sum of lines 1 through 29)									
	NON-REIMBURSABLE EXPENSES									
31.	Federal Income Tax	7910						7		
32.	State Income Tax	7920						7		
33.	Insurance - Officer's Life	7930						7		
34.	Promotion - Advertising and Marketing	7950						7		
35.	Contributions and Donations	7960						7		
36.	Bad Debt	7970						7		
37.	Other Specify:							7		
38.								7		
40.								7		
41.								7		
42.	TOTAL Non-Reimbursable							7		
43.	TOTAL Administrative and General (sum of lines 30 and 42)							7		

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ADMINISTRATORS COMPENSATION

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Name of Individual	Social Security Number	Administrator License Number*	Dates of Employment

Relationship to Provider
☐ Owner or Relative ☐ Non-Owner

1. Base percentage allowance			100%
2. Years of work experience in related work area, if administrative, must be in health care field *(not to exceed 10 years)*		Times 4=	%
3. Years of formal education beyond high school *(not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate degree is not obtained)*		Times 5=	%
3.1 Was baccalaureate degree obtained ? ☐ Yes ☐ No			
4. Duties other than those normally performed by this position where a salary is declared *(not to exceed four extra duties)*.			
a. Accounting			
b. Maintenance			
c. Housekeeping			
d. Other, specify			
e. Other, specify			
Total Duties		Times 4=	%
County Adjustment (see instructions)			%
6. Ownership Points (see instructions)			%
7. Subtotals of lines 1 through 6 (see instructions)			%
8. Allowance Percentage(enter line 7, not exceed 150%)			%

Name of Related Facility	No. Beds	Provider Number	Position	No. Yrs. Exp.	License Number	Dates of Employment (1)	Worked Weekly Hours (2)	Worked Weekly Percent (3)	Compensation Sch. No. (4)	Compensation Line No. (5)	Compensation Amount (6)
This Facility			Administrator						C	1	
TAL											

*QMRP'S AND ADMINISTRATORS OF HOSPITAL BASED LTCF'S REPORT SOCIAL SECURITY NUMBER.

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COMPENSATION OF OWNERS AND/OR RELATIVES
(Other than Administrator)

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Instructions: Detail owners and/or relatives compensation included on ODHS 2524, Schedule B and C.

Individual's Name	Social Security Number	Position	Relationship to Owner	Years of Exper.	Dates of Employment (1)	Worked Weekly		Compensation		
						Hours (2)	Percent (3)	Sch. (4)	Line (5)	Amount (6)

List all compensation received from other long-term care facilities in the Medicaid program (in Ohio and other states) by persons listed above and/or owning a 5% or more interest in this facility.

Individual's Name	Social Security Number	Facility Name	No. Beds	Medicaid Provider Number	Worked Weekly		Amount of Compensation
					Hours	Percent	

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COST OF SERVICES FROM RELATED ORGANIZATIONS*

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

1. In the amount of costs to be reimbursed by the Ohio Medical Assistance Program, are any costs included which are a result of transactions with a related organization? ☐ Yes ☐ No If yes, complete item 2.
2. Does this cost report include payments to related parties in excess of the costs to the related party? ☐ Yes ☐ No If yes, complete item 2.

Name of Owner	Social Security Number	Name of Related Organization	Percent Owner-ship	Sch.	Line	Item	Amount	Cost to Related Organization

3. List each individual who owns, in whole or in part, any mortgage or deed to trust, of the facility or of any property or asset of the facility. (All individuals owning at least 5% of the land, building, business, etc., must be identified.)

Name	Social Security Number	Name	Social Security Number	Name	Social Security Number

4. Is this facility a partnership? ☐ Yes ☐ No If yes, list each partner.
   Is this facility a corporation? ☐ Yes ☐ No If yes, list each corporate officer or director.

* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-26.

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COST OF SERVICES FROM RELATED ORGANIZATIONS*

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

5. List all other Ohio facilities that have ownership, either direct or indirect, in common with this facility.

Provider Name	Provider Number	Number of beds	Provider Name	Provider Number	Number of beds

6. Has any director, office, agent, or managerial employee, or individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended? ☐ Yes ☐ No If yes, list names below.

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Human Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, or the Department of Industrial Relations within the previous twelve months? Yes ☐ No ☐
If yes, list names below.

CONTRACT FOR SERVICES*

8. List all contracts in effect during the cost report year for which the value or cost of the service from any individual or organization is ten thousand dollars or more in a twelve month period.

* FOR FURTHER EXPLANATION SEE OAC RULE 5101:3-3-26.

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COST OF OWNERSHIP TRIAL BALANCE

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

	OWNERSHIP COST CENTERS (1)	Chart of Account (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Allocation (7)	Allocated Adjusted Total (8)
1.	Depreciation - Building	8010				3		
2.	Amortization - Land Improvement	8050				3		
3.	Amortization - Leasehold Improvement	8100				3		
4.	Depreciation - Equipment	8150				3		
5.	Depreciation - Transportation Equipment	8200				3		
6.	Lease and Rent - Building	8250				3		
7.	Lease and Rent - Equipment	8300				3		
8.	Interest Expense - Property/Equipment*	8350				3		
9.	Amortization of Financing Costs	8400				3		
10.	TOTAL Cost of Ownership							

	RENOVATIONS (1)	Chart of Account (2)	Total (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (5)	Ref. (6)	Ratio of Allocation (7)	Allocated Adjusted Total (8)
11.	1981 Depreciation/Amortization & Interest*	8520, 8540				3		
12.	1982 Depreciation/Amortization & Interest*	8520, 8540				3		
13.	1983 Depreciation/Amortization & Interest*	8520, 8540				3		
14.	1984 Depreciation/Amortization & Interest*	8520, 8540				3		
15.	1985 Depreciation/Amortization & Interest*	8520, 8540				3		
16.	1986 Depreciation/Amortization & Interest*	8520, 8540				3		
17.	1987 Depreciation/Amortization & Interest*	8520, 8540				3		
18.	1988 Depreciation/Amortization & Interest*	8520, 8540				3		
19.	1989 Depreciation/Amortization & Interest*	8520, 8540				3		
20.	1990 Depreciation/Amortization & Interest*	8520, 8540				3		
21.	1991 Depreciation/Amortization & Interest*	8520, 8540				3		
22.	1992 Depreciation/Amortization & Interest*	8520, 8540				3		
23.	TOTAL Renovations							

*Specify interest rates: Building _____ % Equipment _____ %

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